Therapeutic Abortion*

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The place of therapeutic abortion in modern medicine is a subject which is most controversial, but one that the medical profession in South Africa should consider very seriously and possibly give a lead in changing the existing legislation. Therapeutic abortion has numerous facets including, medical, ethical, legal, religious, social, demographic and humanitarian, which have been hotly debated all over the world. Perhaps we have been fortunate in that, as yet, there has been little public pressure here to have the law changed as has been the case in the rest of the western world. This will give us time to learn from the experience of other countries where new legislation has been introduced.

Our law in South Africa, as Strauss pointed out in a symposium on therapeutic abortion at Hermanus in 1968,[1] dates back to Common Law authorities and in particular to Roman Dutch authors of the 17th and 18th Century, and in fact is no different from that expounded by Matthaeus in the year 1644.[2] This is no reason for amendment of the law, but it is hardly necessary to point out that since that time medicine has advanced beyond recognition. The leading authors on South African Criminal Law uncritically accept the common law position.

Gardiner and Lansdown[3] state: 'No crime is committed in those instances in which a doctor under the clear dictates of his science, decides that the removal of a foetus is necessary to save the life of the mother'.

As you well know there is a vast literature on the subject of legal abortion and there are very many aspects to consider. I propose in this address to discuss 3 aspects of the subject. These are:

1. Reasons given for changing the existing law.
2. The experience of other countries where the law has been changed.
3. Suggestions on the changes necessary in our law.

*Valedictory address.

REASONS FOR CHANGING THE LAW

Criminal Abortion

One of the main arguments in favour of legalizing abortion and of extending its indications is that the present practice, based essentially on Hippocratic principles, encourages criminal abortion with its attendant hazards. If therapeutic abortion were allowed for socio-economic as well as for strictly medical reasons, this, it is said, would discourage criminal abortion.

The Royal College of Obstetricians and Gynaecologists (RCOG) in its report before the Abortion Act became law in the UK (1967), gave evidence that, except in those countries where abortion on demand and without enquiries is permissible, the legislation of abortion often resulted in no reduction and sometimes in a considerable increase in the number of illegal abortions.

All the Scandinavian countries have liberalized their abortion laws since 1938—although their laws differ in minor aspects. In Sweden, the medical indication for operation was extended in the 1938 Act to include medico-social, humanitarian and eugenic indications. The basic idea underlying the 1938 Act was that the law should have a preventative effect, i.e. that it should reduce the total number of abortions and at the same time be a protection to the women from resorting to unskilled and dangerous methods of terminating their unwanted pregnancies. Although it is difficult to know the exact number of criminal abortions done in a country, reports from Sweden initially indicated that the number of abortions were not significantly reduced. It has only been reduced since the law was amended in 1946 to include socio-medical reasons.

I think, therefore, that it is obvious that the only way to eliminate criminal abortion is to permit unrestricted legal abortion on the demand of any pregnant woman. Although

such a goal may, in fact, be the answer to the problem, our society at this time would not condone such a radical approach to the problem.

Over-population

One of the major problems facing the world of the 1970s is over-population and its consequences. These affect almost every facet of human life including the air we breathe, food we eat, the water we drink, the houses in which we live, our mental health, our relationships with nature and our economic opportunities. The U.S. Academy of Science[4] has stated: 'Either the birth rate of the world must come down or the death rate must go up'. The reduction of the birth rate then is another reason given for changing the abortion laws.

It is quite obvious, however, that for many reasons abortion is not the answer to the population explosion. Of interest is the experience in Japan where this was the reason for introducing the Eugenic Protection Law authorizing abortion in 1948. Despite a fall in the birth rate from 34 per thousand in 1948 to 13·5 per thousand in 1969 and despite a wide-spread programme of contraception, Japan is none the less likely to double its population in 63 years.

It was found in Rumania that legal abortion could be a powerful weapon for population control. Here liberalization of the Abortion Law in 1956 resulted in 1 million abortions being performed in 1965. It was estimated that less than one-fifth of all conceptions produced a baby, probably the highest abortion rate ever recorded. This caused so much concern that in 1965 the law was revised. Control of abortion became stringent and the rate rose immediately from 14 to 40 per thousand in the second half of 1967.

Physical and Mental Health of Mothers

In the practice of medicine today it is very rarely necessary to do a therapeutic abortion to save the life of the mother. Consideration should, however, be given to the physical and mental health of the woman. Legislation which has been introduced in various countries and states of the USA have included this indication and it is regarded as non-controversial. Time does not permit me to say much on this but I will have something to say about mental health of the mother at a later stage.

Congenital Abnormalities

During the 1960s a number of events transpired to focus attention on the abortion problem, not only on the part of the medical profession but, more important, on all segments of society.

The thalidomide tragedy and the congenital abnormalities caused by rubella in early pregnancy were sharp reminders that, as our law stands at present, pregnancy could not be terminated if there was a considerable risk that the baby, if born, would be seriously handicapped, either physically or mentally. By good fortune the thalidomide tragedy was confined mainly to Europe.

The numerous rubella epidemics in South Africa made us only too aware of the problem. In some parts of the country these pregnancies were terminated in good faith, although illegally and there were no prosecutions. In many ways this was most unfortunate in that there was not a test case at that time.

In most countries legislation now allows for termination of pregnancy for foetal conditions. It should be pointed out, however, that for every one malformed foetus ablated, about 5 - 6 entirely normal babies will be destroyed. It is interesting that the California Therapeutic Abortion Act passed in June 1967 makes no provision for foetal damage as an indication for termination of pregnancy.

Socio-economic Reasons

Whether pregnancy should be terminated for socio-economic reasons in the new dimensions of medicine will remain a controversial problem. One hears much of the unplanned pregnancy and the unwanted child. Whether we like it or not, women long to be free from the tyranny of repeated pregnancies; the crippling effect of a large family on its standard of living; psychological theories asserting that an unwanted child may be handicapped throughout its life; above all, the knowledge that means are at hand to control what had hitherto been haphazard—these are some of the reasons for the revolt of women and their husbands against entrenched forms of social customs and religious authority.

Allan Barnes, Professor of Gynaecology and Obstetrics at Johns Hopkins, has, I think, very clearly presented the problem in this way. He says that we are a generation in transition between two points in time. Our patients and society in general, are asking a different contribution from us than was asked a generation ago. As is often the case, to live through a transitional period is difficult for many people. Communities are asking a new attitude of us: that we honestly face and assume the social responsibility which is the hall-mark of our discipline.

The Rights of the Unborn Child

This is the challenge which we as doctors have to face. Unfortunately it highlights two radically opposed views of the unborn child and his rights. On the one hand there is the view which sees the child before birth as being in full possession of unalienable and unviolable rights, above all the right to live. Mrs Knight, a conservative MP in a debate on the Abortion Act in the House of Commons in 1966 said: 'Babies are not like bad teeth to be jerked out because they cause suffering. An unborn baby is a baby nevertheless'.

On the other hand, the unborn child is seen as something less than human; no more than a part of the woman's body which therefore possesses no rights which cannot, at least under certain circumstances, be violated for the safety, well-being or possibly the convenience of parents or society at large.

To put this in another way, it can be said that where, as previously, abortion was a subject of conflicting interest between society which stood for the continued development of the foetus, on the one hand, and the woman on the other, we have now *de facto* gone over to regarding the woman's interest as the most important. The ethical judgements concerning abortion are disappearing, and the question of whether the woman is able to look after a child in the best way is coming more and more into the foreground.

You probably saw 2 news items of interest in medical journals recently. The first was that aborted live foetuses have been sold in England for medical experiments.[5] Subsequently the UK Government announced a committee under Sir John Peel which will enquire into the ethical, medical, social and legal implications of using foetuses and foetal material for research. The other item was that Professor Sanford Katz of the Boston College Law School is studying one of the newest legal specialities—the legal rights of the foetus. In this connection a leading article[6] in the *BMJ* comments that the beginning of human life is, if anything, more difficult to define than its end.

Finally, it is generally agreed that the termination of pregnancy should be allowed for forcible or statutory rape and in incest or in women not capable of realizing the results of coitus, such as mentally deficient women or very young girls.

IN OTHER COUNTRIES

What has been the experience of other countries where the law has been changed? Peter Diggory[7] in an article in *The Lancet* on the preliminary assessment of the 1967 UK Abortion Act in practice, felt that the Act was working satisfactorily—

more so perhaps, than either its opponents or advocates had anticipated. A doctor, in *The Practitioner*[5] of March 1970 stated that the reason life is better for GPs under the Abortion Act, is that the situation in which a patient in distress over an unwanted pregnancy comes to seek advice is now more like a normal medical item of service. Before that it was an episode cluttered with doubts, innuendoes, hypocrisies and ambiguities which nearly became a pantomime of comedy or tragedy. Now, at least, there can be a clear attempt to be honest, sincere and above-board in the doctor/patient relationship, which is a tremendous relief for both the patient and the practitioner, and probably for the gynaecologist too.

I think, however, that it is fair comment that the majority of the medical profession in the UK are far from satisfied with certain aspects of the law. The statistics for the UK and 2 states of America have recently been published and make interesting reading.

During the first 8 months of the Abortion Act (to the end of 1968) 22 252 abortions were performed in the UK. This was equivalent to 35 000 for the full year. In 1969 the figure was 54 157. During the first quarter of 1970 the figure was 17 742 and even if the rate of increase were to level off, this would mean that in 1970 the number would be near 80 000. Of these abortions 55% were in single, widowed, divorced or separated women and the indication was psychiatric in approximately 76% of cases.

In Colorado during the first 12 months after the new law was introduced, 407 therapeutic abortions were performed. In 71·5% of cases psychiatric reasons were given as the indication for abortion and 66% of the patients were single, divorced or widowed.

In the first 12 months of California's new laws, 4 865 abortions were performed. Of all applications submitted for abortion, 91% were approved, 88% of abortions were under the mental health provision and over 50% of the abortions were performed in women who had never been married.

These 3 sets of figures show very clearly the pattern resulting from the new abortion laws. Firstly, the majority of women whose pregnancies are terminated are single, divorced or widowed. Secondly, the main indications for termination of pregnancy are psychiatric reasons. One cannot escape the horrible thought that we are being somewhat hypocritical as a profession to clutch at such a straw in order to meet the problem of abortion on demand. I think that it is obvious that the mental health indications really cover a large number of social and economic conditions which cannot be divorced from the total environment of the patient.

The doctors generally are concerned about the 'social clause' in the Act which makes it legal to terminate pregnancy should the continuation of the pregnancy involve risk to the health of the existing children of the family. This was, and still is, opposed by the British Medical Association and the RCOG. In addition, this also raises a problem between what is ethical and legal. The profession decides its own ethical standards and these are the collective conscience of the profession. The doctors in the UK have clearly stated their views on the ethics of abortion: that it is indicated on medical grounds only and not on social indications. At the moment a pregnancy can be terminated legally for reasons which are not concerned with the health of the mother. Clearly, what is legal is not necessarily ethical. At the annual representative meeting of the BMA in June last year, the following motion 'That this meeting believes that termination of pregnancy performed in good faith within meaning of the Abortion Act is ethical', was lost by a large majority.

The RCOG recently conducted an enquiry into the first year's working of the Act by means of a questionnaire to all gynaecologists employed in the National Health Scheme. The report states that one of the problems causing concern is not so much the working of the Abortion Act, but its interpretation. The legislators, the press, and a small group of agitators have, ever since the enactment, fostered the idea that it provided for abortion on demand, or for social and economical reasons alone.

When the abortion bill was under discussion its advocates repeatedly assured the Houses of Parliament that abortion on demand was not their object. Had they done otherwise, it is unlikely that the bill would have become law. Since the bill was passed, however, there has been a persistent and intense campaign which has had the effect of making the public believe that any woman can have a pregnancy terminated if she so wishes. The Act has also helped the unscrupulous doctor who can now terminate pregnancy virtually on demand and yet still be within the law.

Other points made in these reports are that most gynaecologists found reluctance in nursing staff for the performance of therapeutic abortion; not only was lack of co-operation common, but, in certain centres, individual nurses in the operating rooms and wards refused to assist when termination of pregnancy operations were contemplated. No fewer than 81 consultants met objections from anaesthetists in the cases of abortion operations.

The effect on gynaecological practice has been considerable. In some hospitals the large number of cases requiring termination of pregnancy have disrupted outpatient consultative work, theatre time and hospital beds. Sixty percent of the consultants felt that the Abortion Act would affect recruitment into gynaecology and the result may be a decline in the numbers and quality of future entrants.

In August 1970, more than 240 MPs from both sides of the House of Commons signed a motion calling for an independent enquiry into the working of the Abortion Act and its assessment of the Act on the health, moral and social life of the nation.

Probably the most important outcome of the new abortion laws has been the realization that prevention of an unwanted pregnancy is better than its removal. Consequently Family Planning Clinics have been organized on a national basis and given much-needed financial support.

SUGGESTIONS ON CHANGES

Finally, my views on what changes, if any, one would recommend in our law. Firstly, the most important lesson learned from other countries is that it is essential that a well organized and an efficiently run national family planning programme be started as soon as possible. This presumably would have to be under the direction of the Department of Health, but because of its importance I would like to see a separate department created which could be linked to pollution control. As you know, this is a very topical question, particularly in East London, and I feel the Government should be taking a lead in helping, especially financially, in this problem. Unfortunately, family planning in South Africa has political overtones that complicate the issue, but the Medical Association could actively participate in the education of all section of our population on the advantages of family planning. Vast sums of money and extensive planning would be required for this educational programme but I am sure the money will be well spent. The advent of television in the near future offers a medium which the medical profession can use to good advantage for this and related subjects.

Sterilization of both the male and the female will play an increasingly important part in the limitation in the size of the family and improving the standard of living. Particularly in the lower socio-economic group sterilization has much to offer. The legality of sterilization is obscure since there has never been a case which has been tested by the courts in South Africa or the UK. Machanick[6] in an article in the *S.A. Nursing Journal* (April 1970) states that though there is no statutory regulation bearing on sterilization in this country, recognized authorities on legal medicine are of the firm opinion that it is legal when performed on anybody competent to give consent to an operation, subject only to obtaining consent of both parties in a marriage.

Secondly, the Medical Association should set up a special committee of experts to report on the whole problem of therapeutic abortion and make recommendations. I would like to see the medical profession taking the lead before the advent of public pressure and demands which will surely be with us one of these days.*

*At its 95th ordinary meeting the South African Medical and Dental Council referred the question of therapeutic abortion to its Executive Committee for investigation.—*Editor.*

The new abortion laws enacted in about 12 states of the USA are based on the Model Penal Code set forth by the American Law Institution, and these appear to be satisfactory. In the Code, termination of pregnancy is allowed if pregnancy would gravely impair the physical or mental health of the mother; if there is substantial risk that the child will be born with a grave physical or mental defect; and in pregnancy from rape or incest or other felonious intercourse, including illicit intercourse with a girl under the age of 16 years. The South African Society of Obstetricians and Gynaecologists (SASOG) have, in fact, a draft code of indications for therapeutic abortion which is based on the Model Penal Code.

Interestingly enough, only 5% of the total terminations in the UK were indicated because of the potential risk to the life of the mother and only 3% because of substantial risk of the child being deformed.

From the experience of other countries we can expect the demand and the number of abortions performed to increase considerably if our law is changed as suggested. In three-quarters of all cases the indication will be on mental health grounds which, as I have pointed out, will in fact cover a large number of social and economic conditions.

Other important points which will have to be considered are the following:

1. A conscience clause to release unwilling doctors or institutions from participating in abortion.

2. A residential clause. In England foreign women represented slightly less than 10% of the total number of terminations carried out. In the private sector, however, this percentage was probably greater.

3. Compulsory notification of the details of every legal abortion is essential so that accurate statistics can be kept.

4. Approval should be by 2 or 3 doctors and not by the Tribunal Procedure used in Scandanavia or the Therapeutic Review Committee or Boards popular in the USA. It has been found that with these procedures the loss of privacy to the patient is so great that some women still prefer criminal abortion to retain privacy and the delay in committee action accounted for the high incidence of hysterotomy in Sweden.

5. An important question is: Who would perform the abortions and where should they be done? It may not be realized but about 40% of the abortions performed in the UK are done by doctors on private patients, and of these 90% are done in nursing homes adjacent to Harley Street. Originally the RCOG recommended very strongly that the operator should be a gynaecologist with a consultant appointment in the National Health Scheme and that the operation should be done in a National Health Service Hospital. This advice was not accepted and now one of the difficulties is that the operation is being performed by generally-trained doctors who are making fortunes by specializing in private abortions purely for the money.

It is interesting also that in the private sector the percentage of unmarried women who have abortions performed was more than double those performed in unmarried women in National Health Service Hospitals.

6. One must also consider the possibility of not allowing therapeutic abortion after 14 weeks of pregnancy unless the mother's life is endangered by the pregnancy. It has been found in Europe and in England that the morbidity and mortality is higher when hysterotomy has to be performed or the termination done after the 14th or 16th week of pregnancy.

In conclusion, you have perhaps gathered from my address that I have not formulated any definite ideas on the subject. It is obvious that nobody has found an ideal solution to the problem and that all legislation represents a compromise and is therefore completely satisfactory to few people. One can see the time coming when there will be a total repeal of all abortion laws leaving the matter as a purely medical matter to be decided by the patient and her doctor. My plea is that a National Family Planning Programme be started as a matter of urgency and that a special committee study and report on the whole problem of therapeutic abortion. The Medical Association is ideally placed to take a lead in both these matters.

REFERENCES

1. Strauss, S. A. (1968): S. Afr. Med. J., **42**, 710.
2. Matthaeus, A. II (1644): *De Criminibus ad D.47.5.1.5.* Translation by Benadie, J. T. Pretoria: University of South Africa.
3. Lansdown, C. W. H., Hoal, W. G. and Lansdown, A. V. (1957): *Gardiner and Lansdown's South African Criminal Law and Procedure*, 6th ed., p. 1598. Cape Town: Juta.
4. Taylor, L. R. (1970): *The Optimum Population for Britain.* London: Academic Press.
5. Leading Article (1970): Brit. Med. J., **2**, 433.
6. Leading Article (1970): *Ibid.*, **3**, 420.
7. Diggory, P. (1970): Lancet, **1**, 287.
8. McEwan, J. (1970): Practitioner, **204**, 427.
9. Machanik, G. (1970): S. Afr. Nursing J., **36**, 32.